EDS Research Unit

Research Unit Operating Procedures Manual

LIBRARY REFERENCE NUMBER: SYOP10010 REVISION DATE: JANUARY 2001 VERSION 2.0

INDIANA HEALTH COVERAGE PROGRAMS

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Table of Contents

Section 1: Introduction

Overview

The Research Unit is a group within the EDS Systems Department that provides research services for all other departments in the Indiana Title XIX organization. The unit researches issues forwarded to it after all other attempts to resolve an inquiry have been exhausted by another department. Some issues are claim payment inquiries in which the processing of the claim in the system appears to deviate from specifications documented in the *Pricing Manual*, *Claims Resolutions Manual*, or the Indiana*AIM* Reference subsystem.

The Research Unit also receives research requests from external sources. HealthCare Excel (HCE), the Office of Medicaid Policy and Planning (OMPP), providers, provider associations, or provider groups may initiate external requests. External requests reach the Research Unit through various methods.

The OMPP can send research requests by either contacting the Research Unit directly or the contractor point of contact.

HCE can send research requests by either contacting the Research Unit directly or the contractor point of contact.

Providers, provider associations, and provider groups can send research requests by contacting an EDS provider representative or the contractor point of contact.

The contractor point of contact forwards requests to the Research Unit.

Upon receipt, the Research Unit team lead accesses the research project tracking system (RPTS) to review the request. If the request has not been logged into the RPTS, the Research Unit team lead enters the request into the tracking system. The request initiator can determine the status of these issues by referring to the RPTS.

Section 2: Procedures

Research

Research follows a closed loop of tasks, beginning with an initiator making a request and ending with the resolution communicated to the initiator. This involves the following sequential list of activities:

1. Identify issue
2. Begin preliminary research
3. Forward research issue to Research Unit
4. Research issue in Research Unit
5. Resolve issue

The procedures for these steps are described in detail in the following sections.

Identify Issue

An EDS analyst determines an issue exists. Figure 2.1 illustrates how issues are identified.

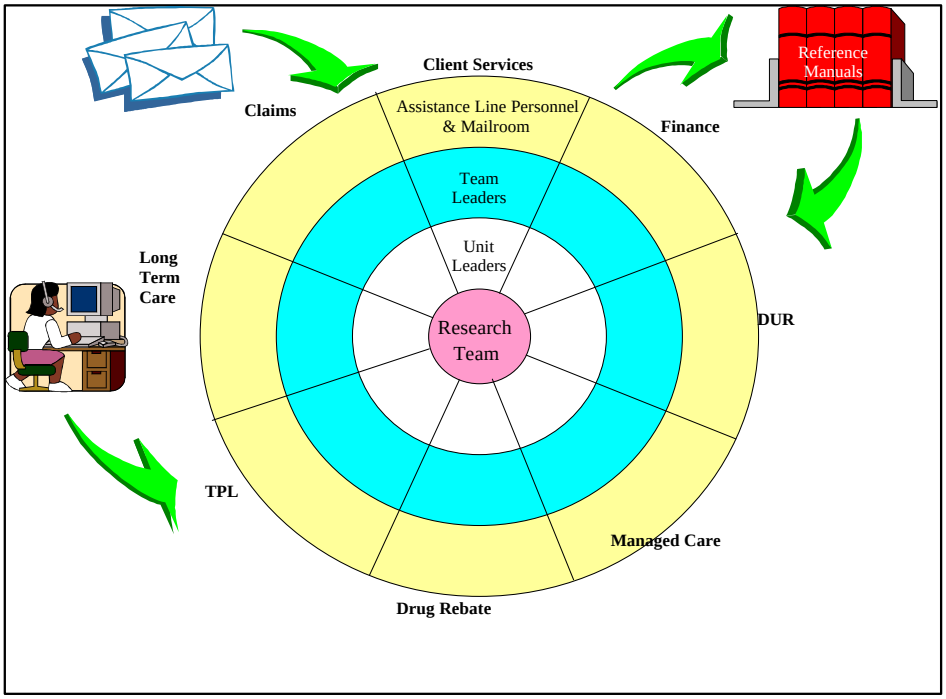

Figure 2.1 – EDS Internal Coordination Diagram

Begin Preliminary Research

The department staff member researches the issue. Department staff members must exhaust all available reference resources while attempting to respond to an issue. The following items must be checked before a Research Service Request (RSR) form is signed and sent to the Research Unit:

Payment Issues Checklist

- Document must have an internal control number (ICN).
- Document must have a provider name and number.
- A screen print must be made of necessary Indiana*AIM* windows.
- The audit trail must be checked to compare the date of service to the date the rate was loaded.
- The pricing payment must be reviewed for method of payment.

Other Issues

- Check the *Indiana Health Coverage Programs Provider Manual*, if applicable.
- Check the reference window with the date of service.
- Check bulletin and banner pages.
- Check the *Medical Policy Manual*, if applicable.
- Check the *Claims Resolution Manual*, if applicable.
- Check the prior authorization (PA) line item table to make sure PA was correct, if applicable.

Forward Research Issue to Research Unit

After all departmental research has been completed with no resolution of an issue, an RSR should be initiated. The RSR form is located at *I:\RSR\requests\rsrmask.doc.* Complete the form and choose **Save As.** Save the document to *I:\RSR\requests\XXXXX.doc.* Print a copy of the RSR and have the department manager sign it. Attach all documentation to the request related to the research in that department. Examples of research-related documentation include *Claims Resolution Manual* pages, *Pricing Manual* pages, Indiana*AIM* screen prints, and bulletins or banner page articles.

> ***Note:*** *The initiator must save the request in the appropriate location. RSR requests not located in I:\RSR\request may be delayed in processing.*

Give the RSR to the Research Unit team lead for review, signature, and distribution. If the issue has not been logged into RPTS already, the Research Unit team lead enters it.

Research Issue in Research Unit

The RSR is assigned to a Research Unit Business Associate (BA). The Research Unit BA conducts research into the issue. Figure 2.2 depicts the usual scenarios followed.

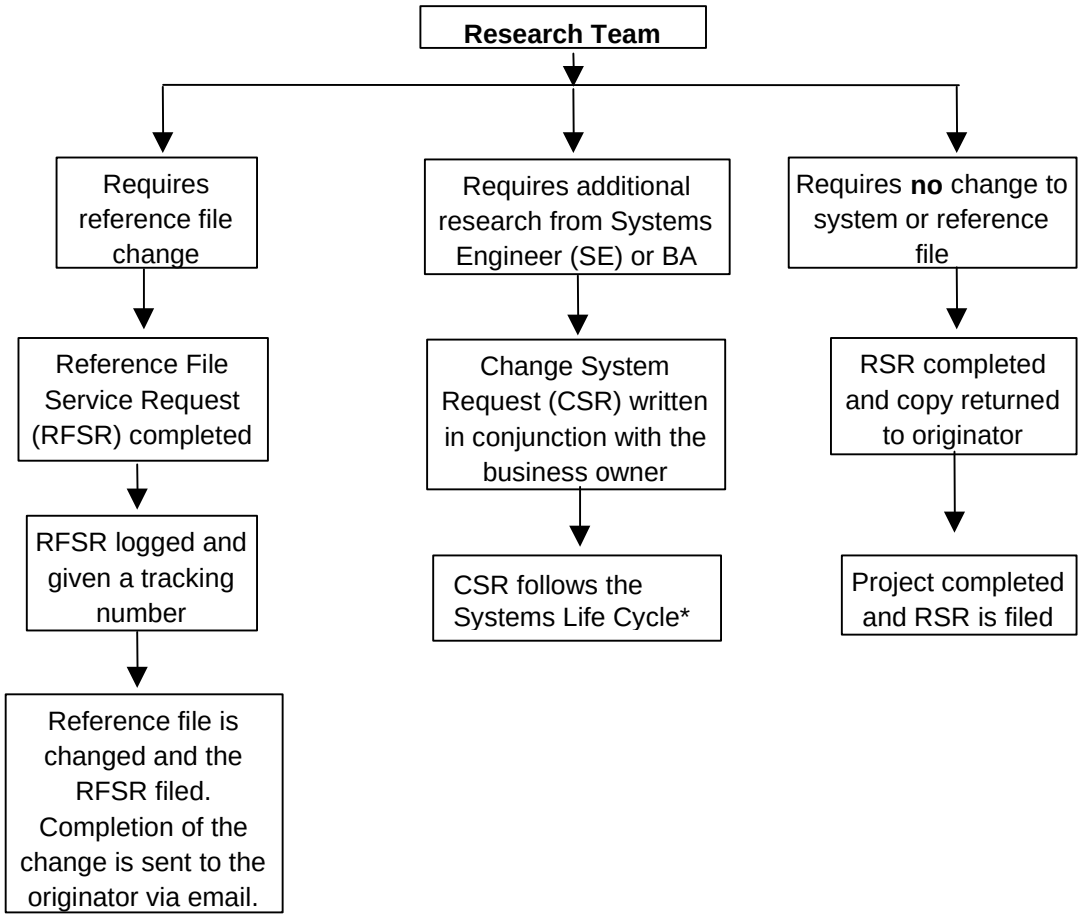

Figure 1.2 – Research Unit

**The Systems Life Cycle is located at L:/projdev/sicdocs/in-CLC 97*

Requires reference file change

A change needs to be made to the reference file. The Research Unit BA works with the RSR initiator to complete the RFSR. The RFSR is logged, assigned a tracking number, and distributed to a Research Unit BA to process the information and make the changes to the system. The RPTS number is indicated on the RFSR form to ensure the documents are linked and that the originator knows where to go to access further information on the RFSR. The Research Unit BA updates the RPTS with the tracking number and closes the RPTS after the reference file change is complete. A quality review is conducted on all RFSRs and the Research Unit works with the RSR initiator to complete any necessary banner pages.

Requires additional research from an SE or BA

The Research Unit BA notifies the initiator that an SE Review Form or a CSR is required to complete the research. The Research Unit BA completes the SE Review Form or the CSR form and solicits assistance from the RSR initiator when necessary. The RPTS is noted on the SE or CSR form to ensure that all parties are aware of the related research request. All CSRs follow the normal Systems Life Cycle procedure.

Note: The Research Unit BA updates the RPTS after a CSR has been assigned a number.

Requires no change to system or reference file

Research determines that no changes need to be made. The Research Unit BA documents the resolution of the issue, completes the Research Task Completion Form, updates the RPTS with the research findings, and changes the status to **Closed**. The Research Unit BA submits an e-mail to the initiator indicating that the request changed to a closed status, and that the findings are documented in the RPTS.

Resolve Issue

The research loop is closed when the Research Task Completion Form is returned to the initiator and the Research Unit BA updates the RPTS.

Some research may result in a need for a **mass adjustment** of claims. The Research Unit BA documents the recommendation on the Research Task Completion Form and forwards it to the initiator. The

initiator, with the approval of its department manager, begins the process for the mass adjustment of claims. The request form and more information are located in *I:\claim\massadj\massform.doc.*

Some research may result in a **manual adjustment** that includes **check** and **non-check** adjustments. The Research Unit BA documents the recommendation on the Research Task Completion Form and forwards it to the initiator. The initiator, with the approval of its department manager, begins the necessary steps to complete the manual adjustment. These steps are located in the *Adjustment Financial Transaction Procedures Manual*.

Process Flow for HCE Requests

Research Service Requests (RSR) from HCE follow the same process described earlier in this section. There are, however, some variations in the receipt and process flow for these requests. These variations are related to coordination with an external customer. The entire receipt and process flow for HCE related requests are outlined in *EDS/HCE RSR* and *RFSR Coordination* in *Appendix C*.

Section 3: Research Request Priority Scale

Priority ranking for RSR is determined using the scale and considerations shown in Table 3.1.

Table 3.1 – Research Request Priority Scale

Ranking Number	Description	Estimated Completion Time Frame
1	Expedite	Completion in 3-7 days
2	Immediate	Completion in 1-2 weeks
3	Standard	Completion in 2-4 weeks
4	Moderate	Completion in 4-6 weeks
5	Projects/Permanent	Completion on-going based on the project work plan and related timeframes
6	Forwarded for further review (SE, HCE, OMPP)	An RSR forwarded to the OMPP, HCE, or an SE is moved to a priority status of "6" until an update is received.

All RSRs are assigned a ranking by the Research Unit team lead upon receipt. All RSRs receive a ranking no greater than three, unless the initiator contacts the Research Unit team lead to negotiate a ranking of one or two. An example of an RSR that would be ranked one or two is research needed to complete a State or Legislative Correspondence. The initiator is notified in an e-mail message that a Research Unit BA has been assigned to the RSR. All initiators are encouraged to use the Business Impact Section of the RSR form to document all relevant information that could have an impact on the completion of the RSR.

The following variables directly affect the assignment of a ranking to an RSR:

1. Directives from the OMPP
2. Government or Legislative involvement, such as a State letter
3. Provider payment that has a direct impact on provider reimbursement, such as claim denials to a large provider group

To ensure that all parties are informed of RSR status, all Research Unit BAs provide a weekly update or all RSRs in their workloads. All updates are made to the RPTS, and an e-mail is forwarded to the initiator and Research Unit team lead to notify them of the update by 12 p.m. EST (Indianapolis time) each Monday. This process allows tracking of all RSRs and ensures that the estimated timeframes are honored.

The OMPP is not involved in ranking an RSR unless the ranking priorities are questioned.

Section 4: Roles and Responsibilities

Introduction

The following outlines the roles and responsibilities of those involved in the Research Service Request (RSR) process.

Research Unit Team Lead

A Research Unit team lead is responsible for coordinating all RSRs forwarded to the Research Unit for review and response. The Research Unit team lead logs all requests in the RPTS and distributes the requests to members of the Research Unit. In addition, the Research Unit team lead monitors the status of all requests to ensure that the assigned priority is honored, and that the originator of the request is given weekly updates. The team lead works closely with internal customers, the OMPP and other contractors to coordinate policy activities.

Research Unit Business Associate

The Research Unit BA supports internal and external customers by providing research services related to program changes and claim matters that appear to deviate from documented specifications. These specifications are documented in the *Pricing Manual, Claims Resolutions Manual, Indiana Health Coverage Programs (IHCP) Provider Manual*, or the Indiana*AIM* Reference subsystem. The Research Unit BA conducts research, coordinates with other parties as needed, and provides a summary of findings to the OMPP, internal customers, and HCE in the RPTS. In addition, the Research Unit BA interacts regularly with all customers to analyze, define, and implement coverage, program, and policy changes in Indiana*AIM*.

System Engineer

The SE coordinates with the Research Unit for requests that require more detailed research at the claims engine or system code tables.

Contractor Point of Contact

The Contractor Point of Contact (CPOC) coordinates with the Research Unit for requests and projects initiated by HCE. The CPOC enters information in the RPTS and attends regular meetings with HCE and the Research Unit to ensure a smooth and timely coordination of requests.

Appendix A: Forms

SUBSYSTEM:	RSR NUMBER:

INDIANA *AIM*

RESEARCH SERVICE REQUEST

REQUESTER NAME: DATE: ____/_____/_____	RELATED CSR's: <List any CSRs to which your request may relate or can be grouped with.>
MANAGER'S APPROVAL SIGNATURE: DATE: ____/_____/_____	SYSTEMS MANAGER APPROVAL SIGNATURE: DATE: ____/_____/_____

ISSUE: <Give a brief title for this issue>

PROBLEM/OPPORTUNITY DESCRIPTION:

<Enter a problem description or an opportunity statement that describes clearly either the problem you are experiencing, or the issue that needs to be resolved. This statement must include enough detail and background information so that anyone reading it will have a general understanding of the problem or modification that you are requesting. When in doubt, provide more detail.>

BUSINESS IMPACT:

<In this section, describe the impact that this problem is causing you, or what the improvement means in terms of your business needs. Provide all information that you have available..>

DESIRED SOLUTION:
<Enter the solution you want to achieve>

ATTACHMENTS:

<Attachments are **required**. Attachments acceptable are screen prints, reports, etc. which indicate the problem situation, and any supporting documentation which describes the correct way the system should be functioning. You must show any research or documentation that you have done on this issue.>

BUSINESS PROJECT OWNER NAME: <This is the name of the person who will participate on the project from a business perspective and will partner with a systems person during the project. A project cannot be started without a business project owner designation.>

Figure A.1 – Research Service Request

RESEARCH CHECKLIST

The following items should be checked before a Research Request Form (RSR) is signed and sent to the Research Unit:

Payment Issues Checklist:

1. Document must have ICN.
2. Document must have a provider name and number.
3. A screen print must be made of necessary *AIM* windows.
4. The audit trail must be checked to compare the date of service to when the rate was loaded.
5. The pricing payment must be reviewed for method of payment.

Other Issues:

1. Check reference window with date of service
2. Check bulletin and banner pages
3. Check Medical Policy Manual, if applicable
4. Check Resolutions Manual, if applicable
5. Check Provider Manual, if applicable
6. Check prior authorization (PA) line item table to make sure PA was correct, if applicable

Figure A.2 – Sample Research Checklist

RESEARCH TASK COMPLETION FORM

Date:

Issue:

Research completed:

Conclusion:

Research Analyst:_____

Manager:_____

Figure A.3 – Research Task Completion Form

Appendix B: SE Review Form

Request for SE Review	
Requester Name:	Date of Request:
Approval Signature:	Date of Approval:
Log Time/RSR #:	
System	
Date of Receipt:	
Approval Signature:	Date:
SE Assigned:	
Explanation of request:	
Conclusion:	
S. E. Review	
Date of Completion:	
SE Signature:	
Upon Completion, Return to :	

Figure B.1 – S. E. Review Form

Appendix C: EDS/HCE RSR and RFSR Coordination Flow Chart

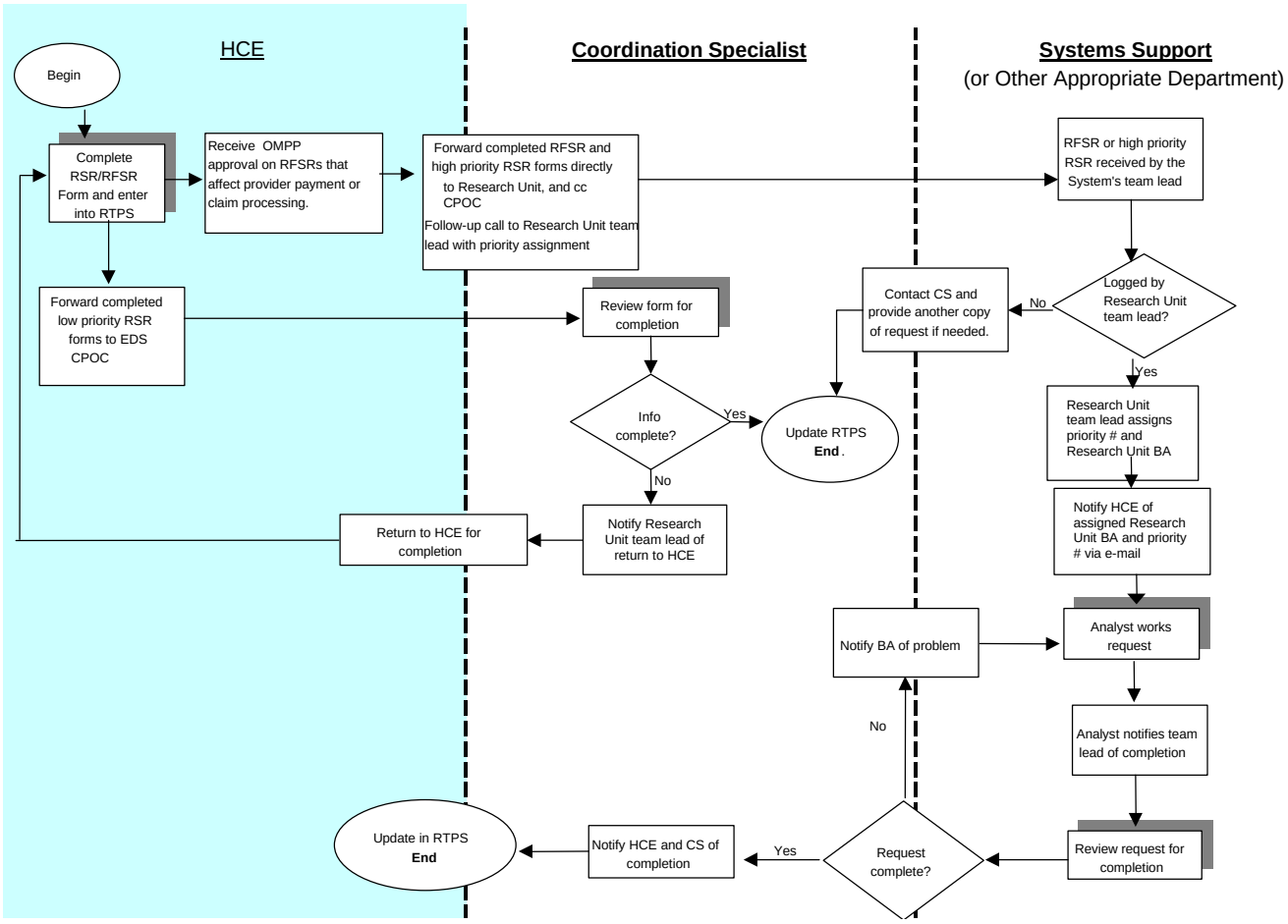

Figure C.1 – EDS/HCE RSR and RFSR Coordination Flow Chart

Glossary

This glossary defines the universal terms of the Indiana Title XIX program as presented in the Request for Proposals (RFP). The spelling and capitalization are approved by the OMPP for use in all documents. Any changes made to the original RFP glossary were made at the request of the OMPP. The terms and definitions in the Indiana Title XIX Common Glossary cannot be changed without contacting the Publications Manager of the Documentation Management Unit, who obtains confirmation and approval from the OMPP. Individual units should include additional terms, as required, in the glossary of their documents.

590 Program

A State of Indiana medical assistance program for institutionalized persons under the jurisdiction of the Department of Corrections, Division of Mental Health, and Department of Health.

ARCH

Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.

AVR

Automated Voice-Response system used by providers to verify member eligibility by phone.

AWP

Average Wholesale Price used for drug pricing.

auto assignment

Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.

BA

Business Associate

BENDEX

Beneficiary Data Exchange. A file containing data from HCFA regarding persons receiving IHCP benefits from the Social Security Administration.

bill

Refers to a bill for medical services, the submitted claim document, or the electronic media claims (EMC) record. A bill may request payment for one or more performed services.

buy-in

A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible medical assistance members, enrolling them in Medicare Part A or Part B or both programs.

CCF	Claim Correction Form. A CCF is generated by Indiana*AIM* and sent to the provider who submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash Control Number. A financial control number assigned to identify individual transactions.
CFR	Code of Federal Regulations. Federal regulations that implement and define Federal Medicaid law and regulations.
claim	A provider's request for reimbursement of IHCP-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: HCFA-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.
contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
contractor, contractors, or the contractor	Refers to all successful bidders for the services defined in any contract.
core contractor	The successful bidder on *Service Package #1: Claims Processing and Related Services*.
core services	Refers to *Service Package #1: Claims Processing and Related Services*.
county office	County offices of the Division of Family and Children. Offices responsible for determining eligibility for IHCP using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by HCFA and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible IHCP members.

CPAS

Claims Processing Assessment System. An automated claims analysis tool used by the State for contractor quality control reviews.

CRF/DD

Community Residential Facility for the Developmentally Disabled.

CSHCS

Children's Special Health Care Services. A State-funded program providing assistance to children with chronic health problems. CSHCS members do not have to be IHCP-eligible. If they are also eligible for IHCP, children can be enrolled in both programs.

CSR

Customer Service Request

customer

Individuals or entities that receive services or interact with the contractor supporting the IHCP program, including State staff, members, and IHCP providers (managed care PMPs, managed care organizations, and waiver providers).

designee

A duly authorized representative of a person holding a superior position.

DHHS

U.S. Department of Health and Human Services. DHHS is responsible for the administration of IHCP at the federal level through the Health Care Financing Administration.

DME

Durable Medical Equipment. Examples: wheelchairs, hospital beds, and other nondisposable, medically necessary equipment.

DPOC

Data Processing Oversight Commission. Indiana state agency that oversees agency compliance with all State data processing statutes, policies, and procedures.

DRG

Diagnosis-Related Grouping. Used as the basis for reimbursement of inpatient hospital services.

DSH

Disproportionate Share Hospital. A category defined by the State identifying hospitals that serve a disproportionately higher number of indigent patients.

DSS

Decision Support System. A data extraction tool used to evaluate IHCP data, trends, and so forth, for the purpose of making programmatic decisions.

DUR

Drug Utilization Review. A federally mandated, IHCP-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.

EAC

Estimated Acquisition Cost of drugs. Federal pricing requirements for drugs.

ECC

Electronic Claims Capture. Refers to the direct transmission of electronic claims over phones lines to Indiana*AIM*. ECC uses point-of-sale devices and PCs for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.

ECS

Electronic Claims Submittal. Claims submitted in electronic format rather than paper. See ***ECC, EMC***.

EDP

Electronic Data Processing.

EFT

Electronic Funds Transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.

EMC

Electronic Media Claims. Claims submitted in electronic format rather than paper. See ***ECC, ECS***.

EOB

Explanation of Benefits. An explanation of claim denial or reduced payment included on the provider's remittance advice.

EOMB

Explanation of Medicare Benefits. A form provided by Indiana*AIM* and sent to members. The EOMB details the payment or denial of claims submitted by providers for services provided to members.

EOP

Explanation of Payment. Describes the reimbursement activity on the provider's remittance advice (RA).

EPSDT

Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for IHCP-eligible members under the age of 21 offering free preventive health care services, such as: screenings, well-child visits, and immunizations. If medical problems are discovered, the member is referred for further treatment.

EVS

Eligibility Verification System. A system used by providers to verify member eligibility using a point-of-sale device, on-line PC access, or an automated voice response system.

FEIN

Federal Employer Identification Number. A number assigned to businesses by the federal government.

FFP

Federal Financial Participation. The federal government reimburses the State for a portion of the IHCP administrative costs and expenditures for covered medical services.

FIPS

Federal Information Processing Standards.

fiscal year - Indiana

July 1 - June 30.

fiscal year - federal

October 1 - September 30.

FSSA

Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the IHCP.

HCBS

Home- and Community-Based Services waiver programs. A federal category of IHCP services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by IHCP. Services are provided to disabled and aged members to allow them to live in the community and avoid being placed in an institution.

HCFA

Health Care Financing Administration. The federal agency in the Department of Health and Human Services that oversees the IHCP and Medicare program.

HCFA-1500

HCFA-approved standardized claim form used to bill professional services.

HCI

Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.

HCPCS

HCFA Common Procedure Coding System. A uniform health care procedural coding system approved for use by HCFA. HCPCS includes all subsequent editions and revisions.

HealthWatch

Indiana’s preventive care program for IHCP members under 21 years of age. Also known as EPSDT.

HIC

Health Insurance Carrier number.

HIO

Health Insuring Organization.

HMO

Health Maintenance Organization.

Hoosier Healthwise	IHCP managed-care program. Hoosier Healthwise has three components including Primary Care Case Management (PCCM), Risk-Based Managed Care (RBMC), and Managed Care for Persons with Disabilities (MCPD).
HRI	Health-Related Items.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.
ICES	Indiana Client Eligibility System. Caseworkers in the county offices of the Division of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
ICF/MR	Intermediate Care Facility For The Mentally Retarded. An ICF/MR provides residential care treatment for IHCP-eligible, mentally retarded individuals.
ICN	Internal Control Number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IMD	Institutions for Mental Disease.
Indiana*AIM*	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).
IOC	Inspection of Care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.
ISMA	Indiana State Medical Association.
ITF	Integrated Test Facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job Control Language.
LAN	Local Area Network.

LOC	Level-of-Care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
lock-in	Restriction of a member to particular providers, determined as necessary by the State.
LTC	Long-Term Care. Used to describe facilities that supply long-term residential care to members.
MAC	Maximum Allowable Charge for drugs as specified by the federal government.
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.
MCO	Managed Care Organization.
MCPD	Managed Care for Persons with Disabilities is one of three delivery systems in the Hoosier Healthwise managed care program. In MCPD, a managed care organization is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the IHCP definition.
MEQC	IHCP eligibility quality control.
MMIS	Medicaid Management Information System. Indiana's current MMIS is referred to as Indiana*AIM*.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
medical policy contractor	Successful bidder on *Service Package #2: Medical Policy and Review Services.*
NCPDP	National Council for Prescription Drug Programs.
NDC	National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.
NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to on-line, real-time eligibility information.

non-core services	Refers to *Service Packages #2 and #3*.
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.
NPIN	National Provider Identification Number.
OMNI	A point-of-sale device used by providers to scan member ID cards to determine eligibility.
OMPP	Office of Medicaid Policy and Planning.
PA	Prior Authorization. Some designated IHCP services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term care resident screening and evaluation services, payable by the IHCP, and authorized by the Omnibus Budget and Reconciliation Act of 1987.
PCCM	Primary Care Case Management. One of three delivery systems within the Hoosier Healthwise managed care program. Providers in PCCM are reimbursed on a fee-for-service basis. Members are assigned to a primary medical provider (PMP) or group that is responsible for managing the care of the member and providing all primary care and authorizing specialty care for the member—24 hours a day, seven days a week.
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to IHCP members assigned to the PMP's care.
POS	Place of Service or Point of Sale, depending on the context.
PPO	Preferred Provider Organization.
PRO	Peer Review Organization.
Pro-DUR	Prospective Drug Utilization Review. The federally mandated, IHCP-specific prospective drug utilization review system and all related services and activities necessary to meet all federal Pro-DUR requirements and all DUR requirements.

QDWI

Qualified Disabled Working Individual. A federal category of IHCP eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.

QMB

Qualified Medicare Beneficiary. A federal category of IHCP eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. IHCP benefits include payment of Medicare premiums, coinsurance, and deductibles only.

RA

Remittance Advice. A summary of payments produced by Indiana*AIM* explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.

RBMC

Risk-Based Managed Care. One of three delivery systems in the Hoosier Healthwise managed care program. In RBMC, a managed care organization is reimbursed on a per capita basis per month to manage the member's health care. The delivery system serves TANF members, pregnant women, and children.

RBRVS

Resource-Based Relative Value Scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.

RFI

Request for Information.

RFP

Request for Proposals.

RFSR

Reference File Service Request

RPTS

Research Project Tracking System

RSR

Research Service Request

SDX

State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.

SE

Systems Engineer

shadow claims

Reports of individual patient encounters with a managed care organization's (MCO's) health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.

SLMB

Specified Low-Income Medicare Beneficiary. A federal category defining IHCP eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. IHCP benefits include payment of the Medicare Part premium only.

SPR

System Performance Review.

SSA

Social Security Administration of the federal government.

SSI

Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.

specialty vendors

Provide support to IHCP business functions but the vendors are not currently IHCP fiscal agents.

State

Spelled as shown, State refers to the State of Indiana and any of its departments or agencies.

subcontractor

Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.

SUR

Surveillance and Utilization Review. Refers to system functions and activities mandated by the Health Care Financing Administration (HCFA) that are necessary to maintain complete and continuous compliance with HCFA regulatory requirements for SUR including the following SPR requirements:

3 statistical analysis

4 exception processing

5 provider and member profiles

6 retrospective detection of claims processing edit/audit failures/errors

7 retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards

8 retrospective detection of fraud and abuse by providers or members

9 sophisticated data and claim analysis including sampling and reporting

10 general access and processing features

11 general reports and output

systems analyst/engineer	Responsible for performing the following activities: 1 Detailed system/program design 2 System/program development 3 Maintenance and modification analysis/resolution 4 User needs analysis 5 User training support 6 Development of personal IHCP program knowledge
TANF	Temporary Assistance for Needy Families. A replacement program for Aid to Families with Dependent Children.
TPL	Third Party Liability.
TPL/Drug Rebate Services	Refers to *Service Package #3: Third-Party Liability and Drug Rebate Services*.
UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and Customary Charge.
UPC	Universal Product Code. Codes contained on the first data bank tape update and/or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal Provider Identification Number.
VFC	Vaccines for Children program.
WAN	Wide Area Network.
WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women, and to infants and children under five years of age.

Index